South Carolina
DEPARTMENT OF HEALTH AND HUMAN SERVICES
Post Office Box 8206
Columbia, South Carolina 29202-8206
www.scdhhs.gov

October 12, 2006

MEDICAID BULLETIN

CHIR	*06-06*	*OMP-NP*	*06-10*
CLTC	*06-10*	*OMP-NPS*	*06-07*
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TO: Providers Indicated

SUBJECT: I. CMS-1500/NPI/NDC Provider Workshops
II. Revised CMS-1500 Form

I. CMS-1500/NPI/NDC Provider Workshops

Workshops are being held to assist providers with questions about implementation of the new CMS-1500, National Provider Identification (NPI), and the new National Drug Code (NDC) billing requirement. Please see the attached schedule for workshop locations and registration instructions.

II. Revised CMS-1500 Form

In response to guidelines set forth by the Centers for Medicare and Medicaid Services (CMS), the South Carolina Department of Health and Human Services is implementing the revised form CMS-1500 (08-05) effective January 1, 2007.

Although the form CMS-1500 (08-05) version will be effective January 1, 2007, use of the revised form is optional until **April 2, 2007**, **unless you are billing for physician-administered drugs (see Medicaid Bulletin dated 9/11/06).** The transitional dual acceptability period of the current and the revised forms is described as follows:

- **January 1, 2007 – March 31, 2007**: Providers can use either the current form CMS-1500 (12-90) version or the revised form CMS-1500 (08-05) version. Note, however, that any providers billing for drugs administered in an office/clinic or other outpatient setting with dates of service on and after January 1, 2007 are mandated to use the revised form to report NDC numbers.

- **April 1, 2007 -** The current form CMS-1500 (12-90) version of the claim form is discontinued; only the revised form CMS-1500 (08-05) is to be used. Note: All rebilling of claims should use the revised form CMS-1500 (08-05) from this date forward, even though earlier submissions may have been on the prior form CMS-1500 (12-90).

A major difference between form CMS-1500 (08-05) and the prior form is the provision for split provider identifier fields. The split fields enable NPI reporting in the fields labeled NPI, and corresponding legacy number reporting in the unlabeled block above each NPI field.

All individuals and organizations who meet the definition of a health care provider as described at 45 CFR 160.103 are eligible to obtain an NPI. If you are one of these providers Medicaid considers you a Typical provider. If you do not meet the definition of a health care provider Medicaid considers you as an Atypical provider (i.e. non-emergency transportation, personal care aid, foster care, etc.) If you are an Atypical provider you should continue to bill Medicaid under your existing six digit Medicaid (legacy) provider ID number in boxes 24J, 32b, and 33b when required. If you are a Typical provider you should bill Medicaid with your 10-digit NPI number in the designated NPI boxes 24J, 32a and 33a when required.

Please refer to the following table for key changes that will affect the Medicaid billing:

1500 Health Insurance Claim Log	
*Required for claim to process **Required if Applicable	
Location	**Change**
Box 17a	Not applicable
Box 17b	Not applicable
Box 19**	If applicable, this box should be used for beneficiaries participating in special programs (*i.e., Medical Homes, PEP, Hospice, etc*) when a referral number is issued by the primary care provider.
Box 21*	The lines after the decimal point in boxes 1, 2, 3, and 4 were extended to accommodate four bytes.
Box 23**	If applicable, enter the prior authorization number for the claim.
Box 24	The line with the alpha indicators was removed. The alpha indicators were moved next to the respective title in the title fields. Each of the six lines was split length-wise and shading was added to the top portion of each line. This area is to be used for the reporting of supplemental information.

1500 Health Insurance Claim Log	
*Required for claim to process **Required if Applicable	
Location	**Change**
Box 24A – Shaded**	Enter the NDC qualifier of **N4,** followed by an 11-digit NDC number. Do not enter a space between the qualifier and the NDC. See example below:

24. A. DATE(S) OF SERVICE						B.	C.	D. PROCEDURES, SERVICES, OR SUPPLIES (Explain Unusual Circumstances)		E.	F.	G.	H.	I.	J.
From			To			Place of				DIAGNOSIS		DAYS OR	EPSDT Family	ID. QUAL.	RENDERING PROVIDER ID. #
MM	DD	YY	MM	DD	YY	Service	EMG	CPT/HCPCS	MODIFIER	POINTER	$ CHARGES	UNITS	Plan		
N400045025446								ML1.25						1D	123456
01	01	07	01	01	07	11		J1631			59 22	2.5		NPI	123456789

Box 24A – Unshaded*	Enter the month, day and year for each procedure, service, or supply.
Box 24B – Unshaded*	Enter the appropriate two-digit code from the Place of Service Code list for each item used or service performed.
Box 24C**	"Type of Service" was removed. This field is now titled "EMG." Leave blank if not an emergency; enter "Y" if an emergency.
Box 24D	The field became wider by three bytes. Shading was added vertically between "CPT/HCPCS" and "MODIFIER."
Box 24D – Shaded area**	Enter the NDC unit of measurement and numeric quantity administered to the patient. Enter the actual metric decimal quantity (units) administered to the patient. If reporting a fraction of a unit, use the decimal point. Maximum number of bytes allowed for the quantity is 13, including the decimal point. Nine numbers may precede the decimal point and 3 may follow the decimal. (*Refer to Medicaid Bulletin dated 9/11/06 regarding NDC Billing Requirements)*
Box 24D – Unshaded area*	Enter the procedure code and, if applicable, the two-digit modifier in the appropriate field. If two modifiers are entered, the first modifier entered will be used to process the claim. For unusual circumstances and for unlisted procedures, an attachment with a description of each procedure must be included with the claim.
Box 24E	Not Applicable.
Box 24F – Shaded area**	Enter the NDC Unit Price if known. The NDC unit price must be a numeric value. If the unit price is not known, submit a value of $0.00.
Box 24F – Unshaded area*	Enter the charge for each listed service. Do not use dollar signs or commas when reporting dollar amounts. Enter 00 in the cents area if the amount is a whole number.
Box 24G – Unshaded area**	If applicable, enter the days or units provided for each procedure listed.
Box 24H – Unshaded area**	If this claim is for EPSDT services or a referral from an EPSDT Screening, enter a "Y."

<table>
<tr><th colspan="4">1500 Health Insurance Claim Log</th></tr>
<tr><td colspan="4">*Required for claim to process
**Required if Applicable</td></tr>
<tr><th>Location</th><th colspan="3">Change</th></tr>
<tr><td>Box 24I</td><td colspan="3">The title was changed from “EMG” to “ID. QUAL.”</td></tr>
<tr><td rowspan="2">Box 24I – Shaded area*</td><td colspan="2">Typical Providers</td><td>Atypical providers</td></tr>
<tr><td colspan="2">January 1, 2007 – May 22, 2007: Enter 1D for the Medicaid qualifier.

May 23, 2007 and after: Enter ZZ for the taxonomy qualifier</td><td>January 1 and after: Enter two byte qualifier 1D for Medicaid</td></tr>
<tr><td>Box 24I – Unshaded</td><td colspan="3">The label “NPI” was added.</td></tr>
<tr><td rowspan="2">Box 24J – Shaded**</td><td colspan="2">Typical Providers</td><td>Atypical providers:</td></tr>
<tr><td colspan="2">January 1, 2007 – May 22, 2007: Enter the current Medicaid Provider ID Number.

May 23, 2007 and after: Enter the Provider taxonomy code.</td><td>January 1 and after: Enter the 6- digit Medicaid Provider ID Number.</td></tr>
<tr><td>Box 24J – Unshaded**</td><td colspan="3">The title was changed from “COB” to “RENDERING PROVIDER ID. #.” The NPI number of the rendering individual provider may be entered here. If the provider is billing as a member of a group, the rendering individual provider’s 10-character NPI number may be entered. The rendering individual provider’s NPI may be reported as early as January 1, 2007; it must be reported on and after May 23, 2007.</td></tr>
<tr><td>Box 24K</td><td colspan="3">This field was removed.</td></tr>
<tr><td>Box 32**</td><td colspan="3">Enter the name, address, and ZIP+4 code of the facility if the services were rendered in a facility other than the patient’s home or provider’s office.</td></tr>
<tr><td>Box 32a**</td><td colspan="3">Enter the NPI of the service facility as soon as it is available. The NPI may be reported as early as January 1, 2007, and must be reported on and after May 23, 2007.</td></tr>
<tr><td rowspan="2">Box 32b **</td><td colspan="2">Typical Providers</td><td>Atypical Providers</td></tr>
<tr><td colspan="2">Prior to May 23, 2007 enter the two-byte qualifier 1D followed by the Medicaid Provider (Legacy) ID number (no spaces).

On and after May 23, 2007, enter the two-byte qualifier ZZ followed by the taxonomy code (no spaces).</td><td>January 1 and after – enter the two-byte qualifier 1D followed by the Medicaid Provider (Legacy) ID number (no spaces).</td></tr>
<tr><td>Box 33*</td><td colspan="3">Enter the provider of service/supplier’s billing name, address, ZIP+4 code, and telephone number. Do not use commas, periods, or other punctuation in the address. When entering a 9-digit zip code (ZIP+4), include the hyphen. Do not use a hyphen or space as a separator within the telephone number.
Claims will be paid to the provider number submitted in box 33 of the CMS-1500 form. This pay-to-provider number is indicated on the Remittance Advice and check.</td></tr>
</table>

<table>
<tr><th colspan="3">1500 Health Insurance Claim Log</th></tr>
<tr><td colspan="3">*Required for claim to process
**Required if Applicable</td></tr>
<tr><th>Location</th><th colspan="2">Change</th></tr>
<tr><td>Box 33a*</td><td colspan="2">Effective May 23, 2007, you MUST enter the NPI of the billing provider or group. If the provider rendering the services is a member of a group, the 10-character NPI group/organization number must be entered. If not billing as a member of a group, enter the 10-character individual NPI number in this box. The NPI may be reported as early as January 1, 2007.</td></tr>
<tr><td>Box 33b*</td><td>Typical Providers</td><td>Atypical Providers</td></tr>
<tr><td></td><td>The title was changed from “GRP#” to “b.” to accommodate the reporting of other ID numbers.

Prior to May 23, 2007 enter the two-byte qualifier 1D followed by the Medicaid Provider (Legacy) ID number (no spaces).

On and after May 23, 2007, enter the two-byte qualifier ZZ followed by the taxonomy code (no spaces). See example below:

Typical Provider Example:</td><td>January 1 and after – enter the two-byte qualifier 1D followed by the 6-digit Medicaid Provider ID number (no spaces).</td></tr>
<tr><td></td><td colspan="2">
<table>
<tr><td colspan="2">33. BILLING PROVIDER INFO & PH # (312) 5552222
Physician Practice Inc.
1234 Healthcare Street
Anytown IL 60610-1234</td></tr>
<tr><td>a. 9876543210</td><td>b. ZZ208D00000X</td></tr>
</table>

Atypical Provider Example:
<table>
<tr><td colspan="2">33. BILLING PROVIDER INFO & PH # (312) 5552222
Physician Practice Inc.
1234 Healthcare Street
Anytown IL 60610-1234</td></tr>
<tr><td>a.</td><td>b. 1D123456</td></tr>
</table>
</td></tr>
</table>

A sample of the revised CMS-1500 form (version 08-05) is attached to this bulletin for information purposes only. The SCDHHS will not supply the CMS-1500 (08-05 version) claim form to providers. Providers should purchase the form in its approved format from the private vendor of their choice.

Thank you for your continued support and participation in the South Carolina Medicaid Program. If you have questions concerning this bulletin, please contact your Program Manager.

/s/

Robert M. Kerr
Director

RMK/rsm

Attachments

NOTE: To receive Medicaid bulletins by email, please send an email to bulletin@scdhhs.gov indicating your email address and contact information.
To sign up for Electronic Funds Transfer of your Medicaid payment, please go to the following link for instructions:
http://www.dhhs.state.sc.us/dhhsnew/serviceproviders/eft.asp